PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, April 24, 2001, at 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Floor 2, Boston, Massachusetts. Present were: Dr. Howard Koh, (Chairman), Dr. Clifford Askinazi, Ms. Phyllis Cudmore, Mr. Manthala George Jr., Ms. Shane Kearney Masaschi, Mr. Albert Sherman, Ms. Janet Slemenda, Dr. Thomas Sterne; and Mr. Benjamin Rubin absent. Also in attendance was Ms. Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½. Chairman Koh announced the deletion of docket item 1C (Request for Approval of Governing Body ByLaws for the Public Health Hospitals) and the presentation of certificate to Dr. Askinazi who is resigning as of May 1, 2001, after serving for five years on the Public Health Council.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Ralph Timperi, Assistant Commissioner, Bureau of Laboratory Sciences, Dr. Alfred DeMaria, Assistant Commissioner, Bureau of Communicable Disease Prevention, Dr. Daniel Friedman, Assistant Commissioner, Bureau of Health Statistics, Research and Evaluation, Deputy General Counsel James Ballin, Dr. Paul Dreyer, Director, Division of Health Care Quality, and Ms. Joyce James, Director, Determination of Need Program.

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETINGS OF SEPTEMBER 26, 2000, OCTOBER 24, 2000, NOVEMBER 21, 2000 AND DECEMBER 19, 2000:

Records of the Public Health Council Meetings of September 26, 2000, October 24, 2000, November 21, 2000 and December19, 2000 were presented. After consideration, upon motion made and duly seconded, it was voted unanimously: That, records of the Public Health Council Meeting of September 26, 2000, October 24, 2000, November 21, 2000 and December 19, 2000, copies of which were sent to the Council Members for their prior consideration, be approved, in accordance with Massachusetts General Laws, Chapter 30A, Section 11A ½.

PERSONNEL ACTIONS:

In a letter dated April 11, 2001, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the reappointments to the consultant and active medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion

made and duly seconded, it was voted unanimously: That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the consultant and active medical staffs of Tewksbury Hospital, be approved for a period of two years beginning April 1, 2001 to April 1, 2003.

REAPPOINTMENTS:

NAME:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Pamela Sheridan, M.D.	74478	Consultant
Michael John, DMD	13404	Active

In a letter dated April 9, 2001, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, recommended approval of the appointment and reappointments to the medical staff of Lemuel Shattuck Hospital, Jamaica Plain. Supporting documentation of the appointees' qualifications accompanied the recommendations. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted unanimously: That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointment and reappointments to the medical staff of Lemuel Shattuck Hospital be approved:

REAPPOINTMENTS:

NAME:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Nicholas Athienties, M.D.	73425	Active/Nephrology
Tai Chung, M.D.	34685	Active/Nephrology
Marshall Folstein, M.D.	77321	Consultant/Psychiatry
Robert Schlesinger, M.D.	32227	Active/Surgery
Scott Shikora, M.D.	57931	Consultant/Surgery

APPOINTMENT: ALLIED HEALTH PROFESSIONAL

NAME:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Myung-Soon Woo-Roderick, NP	181296	Internal Medicine

REAPPOINTMENTS: ALLIED HEALTH PROFESSIONAL

NAME:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Patricia Clifford, PA	211	Orthopedics
Nancy Moczynski, PhD	6590	Psychology
Sally Guy, CNS	161055	Psychiatry
Gloria Shapiro, CNS	100851	Psychiatry

In a letter dated April 3, 2001, Howard K. Koh, Commissioner of Public Health, recommended approval of the appointment of Katharine Thomas to Program Manager V, (Director, Program Policy, Planning and Training). After consideration, upon motion made and duly seconded, it was voted unanimously: That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of Massachusetts General Laws, Chapter 17, Section 6, the appointment of Katharine Thomas to Program Manager V (Director, Program Policy, Planning and Training) be approved.

STAFF PRESENTATION:

"SURVEILLANCE AND RESPONSE PLAN TO REDUCE MOSQUITO BORNE DISEASE TRANSMISSION," BY RALPH TIMPERI, ASSISTANT COMMISSIONER, BUREAU OF LABORATORY SCIENCES:

Mr. Ralph Timperi, Assistant Commissioner, Bureau of Laboratory Sciences said in part, "The West Nile Virus has existed for a long time. It was first recognized in 1937. It caused large outbreaks and sporadic cases throughout Africa, Eastern Europe and the Middle East. However, in1999, it appeared in New York City and caused an outbreak of sixty-two cases of encephalitis with seven deaths. In 2000, there was again an outbreak in New York, a smaller outbreak. Based on the information we got last year from surveillance programs, we are now able to put forth a program this year that we feel will be able to identify risk if it does occur in the Commonwealth. These diseases – West Nile Virus and many other mosquito borne diseases – are typically common infections of birds that do not cause serious illness among the birds. Occasionally a situation develops in the environment where you have many susceptible birds in a particular area, viruses seeded in, and you get large numbers of mosquitoes. So it takes a susceptible bird population, the correct weather conditions to get high numbers of mosquitoes, and there is a virus build-up among the birds. Other species of mosquitoes come along and feed on the birds and then sort of bump into people here and there on a random basis and infect them. It's really an accidental infection of humans that occurs once in a while. That is the good news. Even when there is an outbreak, these diseases are very sporadic. You may have an outbreak and then no human disease for ten, fifteen, twenty years. So we have got a couple of years of difficult times to get through here. We are going to work very hard to tell people where risk occurs and where there is not a risk. Last year, we really did not have the surveillance data to help us identify risk areas early on in the year.

The only surveillance indicators they had last year were infected crows. West Nile Virus in the United States causes high mortality in crows... In 1999, the only real indicator we had was crow deaths. That's what the surveillance program was keyed on. Now we have many layers of surveillance indicators to really help us tell the difference between developing risk and full human risk. That's going to make a big difference in our ability to know when to take action and when we don't need to. What we will be doing this year is to try to make this a normal summer, even if there is a risk of human disease. With the surveillance data, it's going to be very simple. We are going to look for dead birds. Dead birds are an indication of potential virus activity. When we see areas where there are clusters of dead birds, we will be testing a sample of birds to see if they are dying from West Nile Virus infections. If we find West Nile Virus infections in the birds, we will then intensively sample mosquitoes in those areas and we will see if the mosquitoes are carrying West Nile Virus. The transmission to humans obviously is going to come from mosquitoes. So human risk we are going to measure by looking at the virus in mosquitoes. What we would consider a serious situation is an area first that we identify with West Nile Virus in a lot of birds that are going to provide the virus to mosquitoes, and then find that virus in many mosquitoes and many species of mosquitoes. That would be a situation that would be a potential for an outbreak of West Nile Virus."

Mr. Timperi continued, "These outbreaks when they do occur, are very focal. It's not something that occurs statewide. It will be in a small geographic area. So we believe our surveillance program can identify the risk, tell us where the risk is and tell us where the risk is not. Most of the state, even if we do have a serious situation, will not have a virus. We identify the risk and then do the best we can to prevent an outbreak. And that is going to include a lot of public education early in the year. People can on their own really reduce their chance of getting infected, if you reduce your exposure to mosquitoes - if you don't get a lot of mosquito bites. Obviously, a few mosquito bites is not a problem. But we are going to encourage people to reduce their exposure to mosquitoes. We will identify those areas where there are a lot of virus activity and ask them to be particularly cautious. If there is a high risk, we will ask for a little more stringent actions to be taken including larvae control of mosquitoes. This is going to be going on actually in many cities and towns where there was activity last year. The City of Boston will be putting a larvae site in the catch basins where a lot of these mosquitoes breed to keep down these mosquito numbers during the season. And then finally, using a pesticide to kill adult mosquitoes that transmit the disease, if we find an area that we believe may be at risk to an outbreak. So that really is the program. It's a simple program. It's a comprehensive program…"

NO VOTE/INFORMATION ONLY

REGULATIONS:

REQUEST APPROVAL FOR FINAL PROMULGATION OF REGULATIONS ON CONFIDENTIAL BIRTH INFORMATION – 105 CMR 305.000:

Attorney James Ballin, Deputy General Counsel, Department of Public Health said, "We presented these proposed confidential birth information regulations to the Public Health Council for informational purposes in January. These are regulations intended to implement a statutory mandate that the Department have regulations governing the use and disclosure of confidential birth information. The proposed regulations specify acceptable uses of birth information for administrative, statistical and research purposes. They describe minimum criteria for the use of confidential birth information by researchers and establish restrictions on the use and disclosure of confidential birth information. The Department convened a meeting of an advisory committee to the Registry of Vital Records on March 13, 2001 to obtain comments on these proposed regulations. There were no substantive comments received nor changes made based on that meeting. We received written comments by only one person that was representing the Boston Public Health Commission. The Boston Public Health Commission argued that as a public health authority, it should be included in the category of routine recipients for identifying individual level information. The Department believes that the statute specifically limits the dissemination of identifiable birth information except as specifically authorized by this statute. There is no provision in the statute that allows the Department to grant public health authorities unrestricted access to the confidential birth information. However, the regulations do allow public health authorities to have access to individuals records which have been stripped of identifiers, or they can apply for access to identifiable records as any other researcher can."

Attorney Ballin continued, "Another request from the Boston Public Health Commission was with regard to allowing access to aggregate data prior to the Department's public release of that information. They suggested that that be allowed as long as they agree not to release or otherwise publish the information before the Department does. We have agreed to that suggestion. We have made the one change to these proposed regulations since the public hearing. Finally, the Boston Public Health Commission had suggested that the Department eliminate a condition for approval for a researcher that required that the researcher limit the request to only those particular data elements that are absolutely necessary for the proposed research. They suggested that there were some particular reasons in some studies in which they may not know the need for certain variables in advance. Our response to that is that we believe that this condition is appropriate in order to minimize the disclosure of confidential birth information to only that information which is absolutely necessary for the research. The researchers can always amend the request later on if they find that there is a need for additional variables. This is essentially the extent of the comments that were received on these regulations. We request that the Public Health Council approve these proposed regulations for final promulgation."

After consideration, upon motion made and duly seconded, it was voted unanimously (Dr. Clifford Askinazi not present to vote) to **approve Final Promulgation of Regulations on Confidential Birth Information – 105 CMR 305.000**; that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,709.** A public hearing was held on April 12, 2001.

REQUEST APPROVAL FOR FINAL PROMULGATION OF AMENDMENTS TO HOSPITAL LICENSURE REGULATIONS GOVERNING THE PROVISION OF ESSENTIAL SERVICES, 105 CMR 130.000 ET SEQ.:

Dr. Paul Dreyer, Director, Division of Health Care Quality, said in part, "I am here today to request final promulgation of amendments to the hospital licensure regulations that set out procedures governing the discontinuance of essential services to implement Section II of Chapter 141 of the Acts of 2000. We have promulgated these regulations on an emergency basis on December 19, 2000 and held a public hearing on January 29, 2001. Eighteen people attended the hearing and we had testimony from seven individuals or organizations. We have recommended several changes. We are explicitly recognizing several outpatient services as essential. Those are psychiatric, dental, and reproductive health services. Under the regulations promulgated on an emergency basis, it was necessary for a hospital to close its entire outpatient service in order for that closure to be considered the closure of an essential service. What we have done is identified these three particular outpatient services whose closure, by themselves, will result in the triggering of an essential service finding. Several people testified that we should include more explicit timelines in the process, which we have done. We are now requiring that we hold a hearing sixty days prior to the closure, a determination as to whether a plan is necessary fifteen days after the hearing, a plan within fifteen days after that, and a DPH response to the plan ten days after the receipt. None of those timelines were contained in the original promulgation. We have laid out timelines that we need to follow and that the hospital needs to follow once a determination is made that a service is essential and that a hearing is necessary. Several people requested that there be post-closure monitoring. We asked for comments about this point in our original hearing request. We have written the regulations so that the Department is responsible for monitoring what happens after the closure with the cooperation of the hospital, assuming that the hospital remains in existence. What that means in practice is that we will be engaging in a back and forth with the hospital to collect data about what is happening post-closure. We will be comparing that data with what was presented by the hospital in the plan. We have maintained as a definition of service area the medical/surgical definition that we had set forth in the original promulgation. We believe that that is the fairest way to treat all services equally. That is consistent with the way that we deal with most services when we look at an acute care hospital expansion in a regulated context. We have put in some exclusions from the process. And some of these are technical in nature. If a provider is closing at a particular site, that would ordinarily trigger the process. If another provider is taking over at that site with no break in service, then even though the initial provider is closing a service and that ordinarily would trigger the process, if there is no break in service at all, we are excluding that initial closure from the process…"

Dr. Dreyer continued, "One controversial point we have put in is we have given the Commissioner the ability to add a service to the essential services list in extraordinary circumstances. The reason we put this in is we are not certain we have thought of everything that might in fact be essential. We have taken as the basis those services that are defined in the hospital licensure regulations and added the outpatient services. It's certainly possible that six months from now there might be a service that all would agree is essential in the community. And we did not want to deny ourselves the ability to have that service trigger the process. Finally, we have given the Commissioner the designated ability to waive the ninety day timeline in extraordinary circumstances. Here what we have in mind is if a hospital discontinues a service because of a self-identified quality problem, we do not want to make that hospital maintain the service for a ninety-day closure process…I believe that summarizes the changes."

Council Member Thomas Sterne, M.D., said, "I would like to for the record at least, make a set of observations if not questions. It strikes me as an extraordinarily difficult job to write a good set of regulations for, from my personal point of view, a compromised piece of of legislation. While the goal of the legislation and the subsequent regulations appears admirable to me, which is the idea of making public alterations in the provision of services in the health environment so that responsible people can make responsible commentary about it, neither the regulations nor the legislation acknowledge the financial environment in which these decisions about openings and closures and alternations are being made. The vast majority of decisions in this regard are made for predominantly financial reasons in a difficult financial environment at best. I think these regulations will apply to numbers of locations that operate under hospital licenses in a way not necessarily aimed for or designed, and will impose a degree of reporting and scrutiny that heretofore had not been present and is not present in the non-licensure world for ambulatory services. And last, with no disrespect to the Commissioner, the breadth of potential authority open to the Commissioner in situations like this, I fear may be subject to political influence that is not necessarily in the best direction of the regulation. So with those comments, I appreciate all of the work that the people did in constructing the regulations, but I have real concerns about whether this will work ultimately in the public health and the public's best or not best interests."

Dr. Koh responded, "…The whole subject of essential services is a new chapter for us in Public Health and at DPH, and reflects the changing healthcare system and the challenges of maintaining high quality healthcare in our Commonwealth. We have had this provision for a relatively short period of time, so we are trying our best to uphold public health while we look at how we establish these regulations and amend them. The goal throughout is to preserve access to healthcare in the community and to uphold quality of care. I believe that goal was achieved in the first test case that was very public throughout the state in the last several months. If I can say as Commissioner, I think any discretionary authority given to me would be exercised after great caution is expressed through all of the parties involved, through public hearings, through discussion with council members, with people in the community. The whole process has been very, very public. And I can assure you that process will remain very public, because our goal is to

uphold the public health of the community. That is why I think that particular part of the amendment is in there…This process is in evolution, if I can just sum it up."

After consideration, upon motion made and duly seconded, it was voted: Chairman Howard Koh, M.D., Ms. Phyllis Cudmore, Mr. Matt George, Jr., Ms. Shane Kearney Masaschi, Mr. Albert Sherman, Ms. Janet Slemenda in favor; Dr. Thomas Sterne opposed; (Mr. Benjamin Rubin absent; Dr. Clifford Askinazi not present to vote,) **to approve Final Promulgation of Amendments to Hospital Licensure Regulations Governing the Provision of Essential Services, 105 CMR 130.000 et seq.**; that a copy of the approved amendments be attached to and made a part of this record as **Exhibit Number 14,710.** A public hearing was held on January 29, 2001.

DETERMINATION OF NEED PROGRAM:

CATEGORY I APPLICATION:

PROJECT APPLICATION NO. 6-1424 OF NEW ENGLAND HOMES FOR THE DEAF, INC. – NEW CONSTRUCTION TO ADD 18 LEVEL III BEDS TO THE EXISTING 30-BED LEVEL IV FACILITY:

Ms. Joyce James, Director, Determination of Need Program, said, "We are recommending approval of New England Homes for the Deaf, a proposed project to add eighteen Level III beds to its existing thirty Level IV bed rest home. The capital cost for the project is about $1.1 million with operating costs of $680,000. We find that the project, with certain conditions, meets the Determination of Need standards for approval. One of these conditions however, condition number seven on page nine of this summary, should be deleted since level III beds do not require medical recertification. In recommending approval of this project, we must also ask the Council for an exemption to the three year moratorium on construction of new nursing home beds. On October 24, 2000, the Public Health Council adopted an amendment to the determination of need regulations to extend the filing day for applications for construction of new nursing home and rest home beds from January 1, 2000 to January 1, 2003. This decision was based on a projected statewide surplus of beds. There are several reasons why we are requesting an exemption to this moratorium. One is that the New England Homes for the Deaf is the only facility in New England that is specifically designed, equipped and staffed to serve deaf or deaf/ blind seniors. This is not a target population for conventional nursing homes, despite their surplus. Therefore, addition of these beds will not exacerbate under utilized capacity. The second point we wish to make is that the thirty bed rest home currently operates at 98% occupancy. The beds are occupied by equal numbers of Level IV and Level III residents with others on a waiting list. Adding the beds will free up space in the rest home for Level IV residents, while it will provide an appropriate setting for residents requiring Level III nursing care. The final point I would like to make is that in the absence of need, it has been the Department's policy to expand existing services to meet unexpected demand, as this project is proposing."

Ms. Judith Good, President and Chief Executive Officer, New England Homes for the Deaf, said in part, "…There are only two nursing homes, one nursing home currently in the United States that provides the appropriate services for deaf and deaf/blind elders. And that is in Columbus, Ohio. We at New England Homes for the Deaf have had thirty Level IV beds for 100 years…We have nurses on staff around the clock which we are not reimbursed for. We are meeting the need of the population. We have a waiting list of perhaps twenty more beds I could fill. We are only thirty beds. Half of our population is in need of Level III care, which we are providing. But we are providing it in space that really is inappropriate. We ask you to look favorably on this, even though there is a moratorium in this state. When we have to discharge a person, particularly a deaf/blind person or an Alzheimer's patient who is dependent upon a visual mode of communication, or a deaf/blind person who would be dependent upon tactile, they literally sit and waste in a corner in a nursing home, because there is no staff and services or resources for a deaf and blind elder, a frail elder. The other thing I would like to say is there is also no premium or no additional rate. We are not recognized under Management Minutes Questionnaire (MMQs). Deaf and blind would be different. And that will probably be our net argument to another department. But it takes a higher staffing ratio. It takes unique skills…If a deaf elder is at home and needs home health services, there are no communication accessible health services. So they often have caretakers that they cannot communicate with if they want to stay in their home."

Council Member Sherman said in part, "…We are looking at this as a public health issue, and the whole thing is a public health issue. That belongs here without a question…That is what this commission is all about. This is the third commissioner in a row who is concerned about those kinds of real human issues…I think it is something we ought to look at. These are the fragile people in the community that we are sworn to protect probably more than anybody else." Dr. Koh added, "…I view this as an underserved population…We are trying to improve services to the deaf and hard of hearing community in our Commonwealth. We are also trying to improve collaboration throughout New England…" Council Member Janet Slemenda spoke in support of the project, "…I support this tremendously, because in my own family, my aunt, brother, sister, a niece, my own son and myself are all hard of hearing. So we all support this and I understand it."

After consideration, upon motion made and duly seconded, it was voted: unanimously to **approve Project Application No. 6-1424 of New England Homes for the Deaf, Inc. for New Construction to Add 18 Level III beds to the existing 30-bed Level IV facility, (summary of which is attached to and made a part of this record as Exhibit Number 14,711),** based on staff findings, with a maximum capital expenditure of $1,128,310 (December 1999 dollars) and first year incremental operating costs of $680,135 (December 1999 dollars). As approved, the application provides for new construction to add 18 Level III beds to the existing 30 Level IV-bed facility at 154 Water Street, Danvers, MA. This Determination of Need is subject to the following conditions:

1. The Applicant shall accept the maximum capital expenditure of $1,128,310 (December 1999 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. The Applicant shall contribute 10% equity ($112,831 December 1999 dollars) toward the final approved maximum capital expenditure.

3. The Applicant shall, prior to construction, sign a formal affiliation agreement with at least one local acute care hospital and one local home care corporation that includes provisions or respite care services.

4. The Applicant shall establish a plan to protect the privacy, health and safety of the residents during the renovation and construction process, and to ensure that they experience as little disruption as possible in their daily routines.

5. The Applicant shall ensure that any Medicaid transfers from the old facility to the new addition will continue to receive care until such time that Medicaid certification is obtained.

6. The total approved gross square feet (GSF) for this project shall be 7,560 GSF for new construction to add 18 Level III beds.

7. Upon implementation of the project, any assets such as land improvements, or equipment which are either destroyed or no longer used for patient care, shall not be claimed for reimbursement for publicly aided patients.

8. The Department shall reserve the right to conduct a review of the financial feasibility of the project based on the Division of Health Care Finance and Policy's established rates of reimbursement for Medicaid patients at the time final maximum capital expenditures or any adjustments to the final maximum capital expenditures are submitted to the Determination of Need Program for approval in the event that such expenditures exceed the approved maximum capital expenditure. The Applicant shall submit a revised Factor Five (Financial Schedules) upon request by the Department. The Applicant is advised that an increase in equity may be necessary to assure the financial feasibility of the project.

The meeting adjourned at 11:05 a.m.

Howard K. Koh, M.D., MPH
Chairman
Public Health Council

LMH/SB